Senate Bill No. 26

CHAPTER 9

An act to amend Section 104322 of the Health and Safety Code, and to amend Sections 4380, 14005.31, 14005.32, 14011.15, 14067, 14132, 14132.88, 14148.5, and 14154 of, to amend and repeal Section 14110.65 of, and to add Section 14011.16 to, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor May 5, 2003. Filed with Secretary of State May 5, 2003.]

LEGISLATIVE COUNSEL'S DIGEST

SB 26, Committee on Budget and Fiscal Review. Health.

(1) Existing law provides that an appropriation is available for encumbrance during the period specified therein, or, if not otherwise limited by law, for 3 years after the date upon which it first became available for encumbrance. Subdivision (a) of Section 2.00 of the Budget Act of 2002 provides that appropriations in the act, unless otherwise provided, are appropriated for the use and support of the state for the 2002–03 fiscal year.

Existing law establishes the prostate cancer treatment program, administered by the department, under which one or more contracts may be entered into in order to provide prostate cancer treatment services to low-income uninsured and underinsured men.

This bill, commencing with the 2003–04 fiscal year, would require that the amount appropriated to the department for the prostate cancer treatment program be made available for that program, for encumbrance for one fiscal year beyond the year of appropriation, and for expenditure for 2 fiscal years beyond the year of encumbrance, thereby making an appropriation.

(2) Under existing law, the Director of Mental Health, in consultation with the Secretary of Child Development and Education and the Superintendent of Public Instruction, is authorized to award matching grants to local educational agencies to pay the state share of the costs of providing programs that provide school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, in accordance with specified criteria.

This bill would specify that the authority of the director to award these grants is subject to the availability of funding each year.

(3) Under existing law, specified categories of Medi-Cal recipients are required to file reaffirmations of eligibility annually and at other times as required by the department. Existing law requires the department to eliminate, commencing January 1, 2001, the requirement that recipients under the Medi-Cal program file quarterly status reports.

This bill would delete this latter requirement of the department, and, instead, would require, on and after August 1, 2003, that the department require, with certain exceptions, beneficiaries under the Medi-Cal program to file semiannual status reports. The bill would require the implementation of this provision only if and to the extent federal financial participation is available.

(4) Existing law requires the department to develop and conduct a community outreach and education campaign and, contingent upon appropriation, to award contracts to community-based organizations to help families learn about, and apply for, the Medi-Cal program and the Healthy Families Program.

This bill would, instead, authorize the department to perform these activities and would require implementation of the community outreach and education campaign upon an appropriation for that purpose in the annual Budget Act or other statute.

(5) Existing law requires the department, upon federal approval, to provide a supplemental rate adjustment to the Medi-Cal reimbursement rate for specific nursing facilities.

This bill would provide that this provision shall become inoperative on the effective date of this bill and would be repealed on January 1, 2007. The bill would provide that due to the large State Budget deficit projected for the 2003–04 fiscal year, and in order to implement changes in the level of funding for health care services, it is the intent of the Legislature in repealing this provision that no further supplemental rate adjustments be paid to long-term care facilities pursuant to this provision, except that solely for the period February 1, 2002, to December 31, 2002, inclusive, the department shall continue to pay the supplemental rate adjustment to the extent that the department had, on or before December 31, 2002, approved that supplemental rate adjustment for that period.

(6) Under existing law, specified dental services are included as covered benefits under the Medi-Cal program, subject to utilization controls. Existing law prohibits these utilization controls from requiring X-rays as a condition of reimbursement for fillings for children under 18 years of age.

This bill would delete this prohibition, and would revise the covered dental benefits under the program.

(7) Existing law requires the department, in implementing the Medi-Cal program and public health programs, to provide for outreach activities in order to enhance participation and access to perinatal services.

This bill would, instead, authorize the department to perform these outreach activities, and would require these activities upon an appropriation in the annual Budget Act or other statute for this purpose.

(8) Existing law requires the department to establish and maintain a plan to effectively control costs for the county administration of the determination of eligibility for benefits under the Medi-Cal program so that the costs are within the amounts annually appropriated for that administration. The plan is required to establish standards and performance criteria.

This bill would require each county, in administering the Medi-Cal eligibility process, to meet specified performance standards each fiscal year, and report the county's performance, as prescribed, thereby imposing a state-mandated local program. The bill would require a county to submit a corrective action plan to the department regarding any performance standard with which the county is out of compliance. The bill would authorize the department, at its sole discretion, to reduce the allocation of funds as prescribed if a county does not meet the performance standards established by these provisions for eligibility determinations and redeterminations.

(9) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

(10) This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 104322 of the Health and Safety Code is amended to read:

104322. (a) The State Department of Health Services shall develop, expand, and ensure quality prostate cancer treatment to

low-income and uninsured men. The department shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, and the University of California medical centers. The contracts shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(b) Treatment provided under this chapter shall be provided to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level.

(c) The department shall contract for prostate cancer treatment services only at the level of funding budgeted from state and other sources during a fiscal year in which the Legislature has appropriated funds to the department for this purpose.

(d) Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2003 and any other provision of law, commencing with the 2003–04 fiscal year and for each fiscal year thereafter, any amount appropriated to the department for the prostate cancer treatment program implemented pursuant to this chapter shall be made available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for two fiscal years beyond the year of encumbrance.

SEC. 2. Section 4380 of the Welfare and Institutions Code is amended to read:

4380. Subject to the availability of funding each year, the Legislature authorizes the director, in consultation with the Secretary of Child Development and Education and the Superintendent of Public Instruction, to award matching grants to local educational agencies to pay the state share of the costs of providing programs that provide school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, as follows:

(a) The director shall award matching grants pursuant to this chapter to local educational agencies throughout the state.

(b) Matching grants awarded under this part shall be awarded for a period of not more than three years and no single schoolsite shall be awarded more than one grant, except for a schoolsite that received a grant prior to July 1, 1992.

(c) The director shall pay to each local educational agency having an application approved pursuant to requirements in this part the state share of the cost of the activities described in the application.

(d) Commencing July 1, 1993, the state share of matching grants shall be a maximum of 50 percent in each of the three years.

(e) Commencing July 1, 1993, the local share of matching grants shall be at least 50 percent, from a combination of school district and cooperating entity funds.

(f) The local share of the matching grant may be in cash or payment in-kind.

(g) Priority shall be given to those applicants that demonstrate the following:

(1) The local educational agency will serve the greatest number of eligible pupils from low-income families.

(2) The local educational agency will provide a strong parental involvement component.

(3) The local educational agency will provide supportive services with one or more cooperating entities.

(4) The local educational agency will provide services at a low cost per child served in the project.

(5) The local educational agency will provide programs and services that are based on adoption or modification, or both, of existing programs that have been shown to be effective. No more than 20 percent of the grants awarded by the director may be utilized for new models.

(6) The local educational agency will provide services to children who are in out-of-home placement or who are at risk of being in out-of-home placement.

(h) Eligible supportive services may include the following:

(1) Individual and group intervention and prevention services.

(2) Parent involvement through conferences or training, or both.

(3) Teacher and staff conferences and training related to meeting project goals.

(4) Referral to outside resources when eligible pupils require additional services.

(5) Use of paraprofessional staff, who are trained and supervised by credentialed school psychologists, school counselors, or school social workers, to meet with pupils on a short-term weekly basis, in a one-on-one setting as in the Primary Intervention Program established pursuant to Chapter 4 (commencing with Section 4343) of Part 3. A minimum of 80 percent of the grants awarded by the director shall include the basic components of the Primary Intervention Program.

(6) Any other service or activity that will improve the mental health of eligible pupils.

Prior to participation by an eligible pupil in either individual or group services, consent of a parent or guardian shall be obtained.

(i) Each local educational agency seeking a grant under this chapter shall submit an application to the director at the time, in a manner, and accompanied by any information the director may reasonably require.

(j) Each matching grant application submitted shall include all of the following:

(1) Documentation of need for the school-based early mental health intervention and prevention services.

(2) A description of the school-based early mental health intervention and prevention services expected to be provided at the schoolsite.

(3) A statement of program goals.

(4) A list of cooperating entities that will participate in the provision of services. A letter from each cooperating entity confirming its participation in the provision of services shall be included with the list. At least one letter shall be from a cooperating entity confirming that it will agree to screen referrals of low-income children the program has determined may be in need of mental health treatment services and that, if the cooperating entity determines that the child is in need of those services and if the cooperating entity determines that according to its priority process the child is eligible to be served by it, the cooperating entity will agree to provide those mental health treatment services.

(5) A detailed budget and budget narrative.

(6) A description of the proposed plan for parent involvement in the program.

(7) A description of the population anticipated to be served, including number of pupils to be served and socioeconomic indicators of sites to receive funds.

(8) A description of the matching funds from a combination of local education agencies and cooperating entities.

(9) A plan describing how the proposed school-based early mental health intervention and prevention services program will be continued after the matching grant has expired.

(10) Assurance that grants would supplement and not supplant existing local resources provided for early mental health intervention and prevention services.

(11) A description of an evaluation plan that includes quantitative and qualitative measures of school and pupil characteristics, and a comparison of children's adjustment to school.

(k) Matching grants awarded pursuant to this article may be used for salaries of staff responsible for implementing the school-based early mental health intervention and prevention services program, equipment and supplies, training, and insurance.

(*l*) Salaries of administrative staff and other administrative costs associated with providing services shall be limited to 5 percent of the state share of assistance provided under this section.

(m) No more than 10 percent of each matching grant awarded pursuant to this article may be used for matching grant evaluation.

(n) No more than 10 percent of the moneys allocated to the director pursuant to this chapter may be utilized for program administration and evaluation.

Program administration shall include both state staff and field staff who are familiar with and have successfully implemented school-based early mental health intervention and prevention services. Field staff may be contracted with by local school districts or community mental health programs. Field staff shall provide support in the timely and effective implementation of school-based early mental health intervention and prevention services. Reviews of each project shall be conducted at least once during the first year of funding.

(o) Subject to the approval of the director, at the end of the fiscal year, a school district may apply unexpended funds to the budget for the subsequent funding year.

(p) Contracts for the program and administration, or ancillary services in support of the program, shall be exempt from the requirements of the Public Contract Code and the State Administrative Manual, and from approval by the Department of General Services.

SEC. 3. Section 14005.31 of the Welfare and Institutions Code is amended to read:

14005.31. (a) (1) Subject to paragraph (2), for any person whose eligibility for benefits under Section 14005.30 has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with Section 11200), loss of eligibility or termination of cash aid under Chapter 2 (commencing with Section 11200) shall not result in a loss of eligibility or termination of benefits under Section 14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under Section 14005.30 for a person whose eligibility under Section 14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2 (commencing with Section 11200).

(2) Notwithstanding paragraph (1), a person whose eligibility would otherwise be terminated pursuant to that paragraph shall not have his or her eligibility terminated until the transfer procedures set forth in Section 14005.32 or the redetermination procedures set forth in Section 14005.37 and all due process requirements have been met.

(b) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with Section 11200) has ended, but whose eligibility for benefits under Section 14005.30 continues pursuant to subdivision (a), that their benefits will continue.

To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all of the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but shall be required to submit a semiannual status report and annual reaffirmation forms. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's eligibility workers can be contacted.

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 4. Section 14005.32 of the Welfare and Institutions Code is amended to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the

individual to the corresponding Medi-Cal program. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue, and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but shall be required to submit a semiannual status report and annual reaffirmation forms. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in Section 14005.8, 14005.81, or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs, and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided for in Section 14005.37 shall be conducted to determine whether benefits are available under any other provision of law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(b) No later than September 1, 2001, the department shall submit a federal waiver application seeking authority to eliminate the reporting requirements imposed by transitional medicaid under Section 1925 of the federal Social Security Act (Title 42 U.S.C. Sec. 1396r-6).

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of

the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 5. Section 14011.15 of the Welfare and Institutions Code is amended to read:

14011.15. (a) The department shall, not later than July 1, 2000, create and implement a simplified application package for children, families, and adults applying for Medi-Cal benefits. This simplified application package shall include a simplified supplemental resource form.

(b) In developing the application package described in subdivision (a), the department shall seek input from persons with expertise, including beneficiary representatives, counties, and beneficiaries.

(c) The department shall allow an applicant to apply for benefits by mailing in the simplified application package.

(d) The simplified application package shall utilize at a minimum, all of the following documentation standards:

(1) Proof of income shall be documented by the most recent paystub or a copy of the last year's federal income tax return.

(2) Self-declaration of pregnancy.

(3) A simplified supplemental resource form, if applicable.

(e) The department shall not require an applicant who submits a simplified application pursuant to this section to complete a face-to-face interview, except for good cause, a suspicion of fraud, or in order to complete the application process. A county shall conduct random monitoring of the mail-in application process to ensure appropriate enrollment. Every application package shall contain a notification of the applicant's right to complete a face-to-face interview.

(f) The department shall implement this section only to the extent that its provisions are not in violation of the requirements of federal law, and only to the extent that federal financial participation is available.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter

3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 6. Section 14011.16 is added to the Welfare and Institutions Code, to read:

14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department's procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The department shall explore the feasibility of using a form that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

(b) Beneficiaries who have been granted continuous eligibility under Section 14005.25 shall not be required to submit semiannual status reports. To the extent federal financial participation is available, all children under 19 years of age shall be exempt from the requirement to submit semiannual status reports.

(c) Beneficiaries whose eligibility is based on a determination of disability or on their status as aged or blind shall be exempt from the semiannual status report requirement described in subdivision (a). The department may exempt other groups from the semiannual status report requirement as necessary for simplicity of administration.

(d) When a beneficiary has completed, signed, and filed a semiannual status report that indicated a change in circumstance, eligibility shall be redetermined.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) This section shall be implemented only if and to the extent federal financial participation is available.

SEC. 7. Section 14067 of the Welfare and Institutions Code is amended to read:

14067. (a) The department, in conjunction with the Managed Risk Medical Insurance Board, may develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal and the Healthy Families Program of the Managed Risk Medical Insurance Board, subject to the requirements of federal law. In conducting this campaign, the department may seek input from, and contract with, various entities and programs that serve children,

including, but not limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children to assist in the outreach, education, and application completion process. The department shall implement the campaign if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(b) An annual outreach plan shall be submitted to the Legislature by April 1 for each fiscal year for those years for which there is funding in the annual Budget Act or other statute for the outreach and education campaign. The plan shall address both the Medi-Cal program for children and the Healthy Families Program and, at a minimum, shall include the following:

(1) Specific milestones and objectives to be completed for the upcoming year and their anticipated cost.

(2) A general description of each strategy or method to be used for outreach.

(3) Geographic areas and special populations to be targeted, if any, and why the special targeting is needed.

(4) Coordination with other state or county education and outreach efforts.

(5) The results of previous year outreach efforts.

(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any such contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(d) (1) The department, in conjunction with the Managed Risk Medical Insurance Board, may award contracts to community-based organizations to help families learn about, and enroll in, the Medi-Cal program and Healthy Families Program, and other health care programs for low-income children. The department shall implement this subdivision if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Contracts for these outreach and enrollment projects shall be awarded based on, but not limited to, all of the following criteria:

(A) Capacity to reach populations or geographic areas with disproportionately low enrollment rates. If it is not possible to estimate the number of uninsured children in a geographic area who are eligible for the Medi-Cal program or the Healthy Families Program, proxy measures for rates of eligible children may be used. These measures may

include, but are not limited to, the number of children in families with gross annual household incomes at or below the federal poverty levels pertinent to the programs.

(B) Organizational capacity and experience, including, but not limited to, any of the following:

(i) Organizational experience in serving low-income families.

(ii) Ability to work effectively with populations that have disproportionately low enrollment rates.

(iii) Organizational experiences in helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program. Organizations that do not have experience helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program shall be eligible only to the extent that they support and collaborate with the outreach and enrollment activities of entities with that experience.

(C) Effectiveness of the outreach and education plan, including, but not limited to, all of the following:

(i) Culturally and linguistically appropriate outreach and education strategies.

(ii) Strategies to identify and address barriers to enrollment, such as transportation limitations and community perceptions regarding the Medi-Cal program and Healthy Families Program.

(iii) Coordination with other outreach efforts in the community, including the statewide Healthy Families Program and Medi-Cal program outreach campaign, the state and federally funded county Medi-Cal outreach program, and any other Medi-Cal program and Healthy Families Program outreach projects in the target community.

(iv) Collaboration with other local organizations that serve families of eligible children.

(v) Strategies to ensure that children and families retain coverage and are informed of options for health coverage and services when they lose eligibility for a particular program.

(vi) Plans to inform families about all available health care programs and services.

SEC. 8. Section 14110.65 of the Welfare and Institutions Code is amended to read:

14110.65. (a) (1) The department shall, upon federal approval of a federal Medicaid State Plan amendment authorizing federal financial participation, provide a supplemental rate adjustment to the Medi-Cal reimbursement rate for specific nursing facilities, intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, intermediate care facilities/developmentally disabled-nursing, and pediatric subacute units that have a collectively bargained contract or a comparable, legally

binding, written commitment to increase salaries, wages, or benefits for nonmanagerial, nonadministrative, noncontract staff. It is the intent of this section to make this supplemental rate adjustment available to both facilities with collective bargaining agreements and facilities without collective bargaining agreements that meet the requirements of this section. The supplemental rate adjustment shall be sufficient to fund the Medi-Cal portion of each facility's commitment that exceeds the labor cost adjustment for the covered employees that is already included in the Medi-Cal base reimbursement rate. Starting on the date of federal approval of the Medicaid State Plan amendment and at the start of each rate year thereafter, the supplemental rate adjustments made pursuant to this section shall occur for the commitments that increase salaries, wages, or benefits during the rate year as compared to the salaries, wages, or benefits paid in the preceding year. These supplemental rate adjustments shall be subject to certification of the availability of funds by the Department of Finance on May 15 of each year for the following fiscal year, and subject to the extent funds are appropriated for this purpose in the annual Budget Act. Authorization for the supplemental rate adjustments shall terminate on the date of implementation by the department of a Medi-Cal reimbursement system that uses facility-specific rates for nonhospital based nursing facilities covered by this section.

(2) For a specific facility to be eligible for the supplemental rate adjustment, the facility shall submit the following to the department:

(A) Proof of a legally binding, written commitment to increase the salaries, wages, or benefits of existing and newly hired employees, excluding managers, administrators, and contract employees, during the rate year.

(B) Proof of the existence of a method of enforcement of the commitment, such as arbitration, that is available to the employees or their representative, and all of the following apply.

(i) It is expeditious.

(ii) It uses a neutral decisionmaker.

(iii) It is economical for the employees.

(C) Proof that the specific facility has provided written notice of the terms of the commitment and the availability of the enforcement mechanism to the relevant employees or their recognized representatives.

(3) For purposes of this section, a supplemental rate adjustment shall equal the Medi-Cal portion of the total amount of any increase in salaries, wages, and benefits provided in the enforceable written agreement minus any increase provided to that facility during that rate year provided in the standardized rate methodology (Medi-Cal base

reimbursement rate) for labor related costs attributable to the employees covered by the commitment. Any supplemental rate adjustment made pursuant to this section shall only cover the period of the nonexpired, enforceable, written agreement. The department shall adjust the methodology for determining costs in the future rate determinations.

(4) Any supplemental rate adjustment for any facility under this section shall be no more than the greater of either of the following:

(A) Eight percent of that portion of the facility's per diem labor costs, prior to the rate year, attributable to employees covered by the commitment.

(B) Eight percent of the facility's peer group's per diem labor costs multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the commitment.

(5) The department shall terminate the adjustment for the specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(6) The department may inspect relevant payroll and personnel records of facilities receiving funds pursuant to this section in order to ensure that the salary, wage, and benefit increases provided for in this section have been implemented. In addition to the remedies provided in subdivision (b), the department may retroactively recover funds provided to a facility for labor costs incurred after expiration of the commitment or due to the failure of the facility to comply with the commitment.

(7) An employees enforcement or attempted enforcement of the written commitment pursuant to paragraph (2) of subdivision (a) shall not constitute a basis for adverse action against that employee.

(b) The department shall provide instructions on facility requirements by November 1, 2001, or at least 60 days before implementation of this section, whichever is earlier. In developing these instructions, the department shall consult with provider and employee representatives. Audit, exit conference, and other review protocol for determining facility compliance with this section shall be developed by the department after consulting with provider and employee representatives. Any facility that is paid under the supplemental rate adjustment provided for in this section that the director finds has not provided the salary, wage, and benefit increases provided for shall be liable for the amount of funds paid to the facility by this section but not distributed to employees for salary, wage, and benefit increases, plus a penalty equal to 10 percent of the funds not so distributed. Recoupment of funds from any facility that disagrees with the findings of the director specific to this section and has filed a request for hearing pursuant to Section 14171, shall be deferred until the request for hearing is either

rejected or the director's final administrative decision is rendered. Interest shall be applied to any recoupment amount at the interest rate and timeframes specified in subdivision (h) of Section 14171. The facility shall be subject to Section 14107.

(c) This section shall become inoperative on the effective date of the act that added this subdivision, and, as of January 1, 2007, is repealed, unless a later enacted statute that is enacted before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 9. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to

require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, ‘‘in-home medical care service’’ includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and

meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client’s needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in

paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, ''comprehensive clinical family planning services'' means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 10. Section 14132.88 of the Welfare and Institutions Code is amended to read:

14132.88. (a) Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits for beneficiaries 21 years of age or older under this chapter:

(1) One dental prophylaxis cleaning per year.

(2) One initial dental examination by a dentist.

(b) The following are covered benefits for beneficiaries under 21 years of age under this chapter:

(1) Two dental prophylaxis cleanings per year.

(2) Two periodic dental examinations per year.

(c) For persons 21 years of age or older, laboratory-processed crowns on posterior teeth are not a covered benefit except when a posterior tooth is necessary as an abutment for any fixed or removable prosthesis.

(d) Any prefabricated crown made from ADA-approved materials may be used on posterior teeth and may be reimbursed as a stainless steel crown.

(e) The department shall reduce the rate of subgingival curettage and root planing by 41 percent for all beneficiaries except those residing in a skilled nursing facility or an intermediate care facility for the developmentally disabled. Notwithstanding Section 14105 and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin or similar instruction, without taking regulatory action.

(f) The department shall require documentation on claims to establish the medical necessity for dental restorations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin or similar instruction, without taking regulatory action.

SEC. 11. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) State funded perinatal services shall be provided under the Medi-Cal program to pregnant women and state funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 200 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims, except as follows:

(1) The assets of the family shall not be considered in making the eligibility determination.

(2) The income deduction specified in subdivision (f) of Section 14148 shall not be applied.

(b) Services provided under this section shall not be subject to any share-of-cost requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the Managed Risk Medical Insurance Program's Access for Infants and Mothers component, may provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. These

outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.

(2) Those outreach activities authorized by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal eligible high risk or uninsured pregnant women and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted women on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other provision of law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(e) The programs authorized in this section shall be operative for the entire 1996–97 fiscal year.

SEC. 12. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office. The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the Aid to Families with Dependent Children (AFDC), Food Stamp, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget,

administer, and allocate state funds for county administration in a uniform and consistent manner.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. Nothing in this section shall be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(C) Notwithstanding the rulemaking procedures of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters or similar instructions, without further regulatory action.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redeterminations shall be commenced by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(d) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(e) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(f) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard of standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(g) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

SEC. 13. (a) Due to the large State Budget deficit projected for the 2003–04 fiscal year, and in order to implement changes in the level of funding for health care services, it is the intent of the Legislature in repealing Section 14110.65 of the Welfare and Institutions Code in Section 9 of this act that no further supplemental rate adjustments be paid to long-term care facilities pursuant to Section 14110.65 of the Welfare and Institutions Code.

(b) After the effective date of this act, the State Department of Health Services shall not pay any supplemental rate adjustment pursuant to subdivision (a) of Section 14110.65 of the Welfare and Institutions Code, except as provided in subdivision (c).

(c) Solely for the period beginning February 1, 2002, to December 31, 2002, inclusive, the State Department of Health Services shall continue to pay any supplemental rate adjustment pursuant to subdivision (a) of Section 14110.65 of the Welfare and Institutions Code to the extent that the department had, on or before December 31, 2002, approved that supplemental rate adjustment for that period.

SEC. 14. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

SEC. 15. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to address the State Budget crisis at the earliest possible time, it is necessary that this act take effect immediately.

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